

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>TN0610</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/19/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>ROAN HIGHLANDS NURSING CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>146 BUCK CREEK ROAD ROAN MOUNTAIN, TN 37687</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
N 000	Initial Comments  During investigation of C/O #27172 and #27663, conducted May 16 and 17, 2011, at Roan Highlands Nursing Center, no deficiencies were cited under Chapter 1200-8-6, Standards for Nursing Homes.	N 000			

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

YUX011

If continuation sheet 1 of 1